MINUTES
Stakeholder Conference Call
July 14, 2006

Attendees: Stakeholders, Regional Community Services Staff, HarmonyIS Milestone Oversight team, HealthCarePerspective LLC team, and Fordyce Mitchel, Daphne Rosalis

1. Questions from the regional meetings that were not able to be answered at that moment have been asked and clarified. Below are answers to some of those questions.

- If I submit a claim and it has not been sent to EDS from MRSIS can I go back into MRSIS and make corrections?
    - Yes, there will be a natural stopping point in the process where MRSIS will collect claims then send them to EDS at a specified time. If you need to make revisions to a claim that has been submitted, adjudicated by MRSIS, but not sent to EDS you will be able to do so. There will be a limited window of opportunity to do this.
- Will there be a way to copy a previously submitted bill into a new claim, change the dates, and submit the claim for the current time frame?
    - No, there will not be a way to copy previously billed claims.
- If you exceed the monthly units on the Plan of Care will the POC need to be revised or will a justification of the overage be acceptable?
    - We will prior authorize the Plan of Care for a year, as long as you don't exceed the overall authorized units it would appear to be okay to use more in one month and less in another. For the purpose of a Medicaid audit, it is advised that diligent documentation and justification accompany progress notes anytime the POC units have been exceeded.

      We have asked that Harmony produce a report that will show billed units for services. This report would be available to case managers to help recognized when services have exceeded the POC units in order to help with the justification process. Fordyce Mitchel has asked Medicaid about this specific issue. His proposal is that as long as the monthly overage (or underage) is less than 20% (which could be lowered at Medicaid's request) then the provider should be the one to document the reason for using more (or less) units than the POC specifies. The report that has been mentioned will be a paid claims report and is to be provided to case managers through their access to MRSIS. It will show how many units got billed for their clients in a previous month. It will be after the fact because you have to wait for the direct care provider to bill for the services that have been provided. If we are talking about April ideally the case manger would have a report by the end of May, but if the provider has not billed for the services yet they won't get that report until June or July. I'm not sure how useful the report will be but it may help.
- Will the case manger supervisor be able to review and approve information before it is submitted to the regional office such as the waiting list information and the waiver

enrollment information? Could there also be a supervisor review of claims information before submitting claims to MRSIS?

- Yes and no, we are setting up a second level security tier by which an additional review and approval (by the case manger supervisor) must take place before the case manager can be submitted data to the regional office. This level of approval can not be placed on the claims process. Once a claim has been entered into MRSIS and submitted it will be sent to MRSIS for adjudication.

- Will the direct provider be able to review the Plan of Care through Two-Part Harmony?
  - Yes, there should be a number of reports that the provider can access through Two-Part Harmony. One such report will be the Plan of Care. Other reports include the 270/271 eligibility report, Remittance Advice, and Prior Authorization reports. We intend to do a data exchange with Medicaid two to four times a month so that we can stay as up to date as possible on our clients Medicaid eligibility. We will know for a given consumer if he/she is eligible for a given time period. So, if we are able to post this via a report to case managers and providers then it might help us help our clients stay Medicaid eligible.
- Will the case manger supervisor have access to all the outstanding tasks associated with their case managers?
  - Yes, there will be a "tickler" list that will allow them to go into any of their case manager's outstanding task list and if needed they could complete the outstanding task for a case manager.

Those were some outstanding questions that we were able to get clarification on. There is a summary of most (if not all) the questions that were asked during the regional provider meeting about MRSIS and the answers on the web site. In addition, the Power Point presentation that was shown during the regional meetings will be posted on the web site. The Minutes from our Stakeholder Conference Calls have been updated and will be posted as well.

2. One of the questions that came out of Region 1 (Decatur) was about the prior authorization process. We had a conference call and a meeting with our consultants and the Harmony folks to make sure we were all on the same page. We've also talked to all of our fiscal folks to make sure we're all on the same track. Prior authorizations for each client will be on a fiscal year basis. If a person comes into services in January his/her prior authorization will run from whatever date he/she enters the waiver in January until the end of August (August 31st). The following year, effective September 1st, the person will have a prior authorization for a full twelve months. These dates do not synchronize with the Plan of Care. However, the services in the POC will be in the prior authorization, but when the POC is changed there will have to be a manually check to ensure that there is enough money to cover the units. There was no way around this. We have to make the POC synchronize with the LTC2 dates (these are the waiver segment dates assigned by EDS). The good news for the provider is there will (in most cases) be one prior authorization number to keep track of for a year.

We brought our fiscal officers in to Central Office last week to train them on the pre-loading of the prior authorizations in Harmony. That process has now begun. The basis for the prior authorizations that they are loading is information that the provider was asked to submit a couple of months ago on an Excel spreadsheet. On the spreadsheet providers were asked to name the people who get services, the services they receive, and to indicate what the match source was for that service. This was the opportunity for providers to assign match sources. Some providers have sent this information and some have not. What the regional managers have told us is that 60-70% of the providers have completed the spreadsheet correctly. The other 30-40% said everybody is state match or everybody is local match or didn't answer the questions at all. The regional managers will be following up with those providers to get clarification. If the people don't get assigned to the correct match source by the provider we will have to assign them to a match source on our own. We will share the information with the provider, but if the provider doesn't assign the match source we will have to.

The training for the prior authorization went well. The module is an old Harmony module that is no longer in use, but it was user friendly and the fiscal managers did not have any problems using the tool. It was encouraging to get our hands on the first live component of the Harmony system.

We are still in the building stage so we don't have a lot of exciting news to share with providers, but we will continue our conference calls to keep everyone up to speed.

No Questions. Next conference call will be held on July 28th, 2006.